SERVICE PROVIDER MONTHLY TREATMENT & PROGRESS SUMMARY
Child and Adolescent Mental Health Division (CAMHD)

Instructions: Please complete, mail and/or FAX this form by the 5th working day of each month (summarizing the time period of 1st to the last day of the previous month) to your client's Family Guidance Center. The information will be used in service review, monitoring, planning and coordination in accordance with CAMHD policies and standards. Mahalo!

Client Name:		CR #:	DOB:
Home School:	Complex:	FGC:	IDEA/504 Status:
Primary Dx:	Level of Care (one per form):		Month/Year of Services:

Service Format (circle any that apply):
Individual Group Parent Family Teacher Other: _____

Service Setting (circle any that apply):
Home School Community Out of Home Clinic/Office Other: _____

Service Dates:																

Targets Addressed This Month (*number* up to 10):

	Activity Involvement		Contentment, Enjoyment, Happiness		Learning Disorder, Underachievement		Phobia/Fears		Sleep Disturbance
	Academic Achievement		Depressed Mood		Low Self-Esteem		Positive Thinking/ Attitude		Social Skills
	Aggression		Eating, Feeding Problems		Mania		Psychosis		Speech and Language Problems
	Anger		Empathy		Medical Regimen Adherence		Runaway		Substance Use
	Anxiety		Enuresis, Encopresis		Oppositional/ Non-Compliant Behavior		School Involvement		Suicidality
	Assertiveness		Fire Setting		Peer Involvement		School Refusal/Truancy		Traumatic Stress
	Attention Problems		Gender Identity Problems		Peer/Sibling Conflict		Self-Control		Treatment Engagement
	Avoidance		Grief		Personal Hygiene		Self-Injurious Behavior		Willful Misconduct, Delinquency
	Cognitive-Intellectual Functioning		Health Management		Positive Family Functioning		Sexual Misconduct		Other:
	Community Involvement		Hyperactivity		Positive Peer Interaction		Shyness		Other:

Progress Ratings This Month (check appropriate rating for any target numbers endorsed above):

#	Deterioration < 0%	No Significant Changes 0%-10%	Minimal Improvement 11%-30%	Some Improvement 31%-50%	Moderate Improvement 51%-70%	Significant Improvement 71%-90%	Complete Improvement 91%-100%	Date (If Complete)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

CR # _____ (please repeat the number here)

Intervention Strategies Used This Month (check all that apply):

	Activity Scheduling		Eye Movement, Tapping		Marital Therapy		Play Therapy		Stimulus or Antecedent Control
	Assertiveness Training		Family Engagement		Medication/Pharm-acotherapy		Problem Solving		Supportive Listening
	Biofeedback, Neurofeedback		Family Therapy		Mentoring		Psychoeducation, Child		Tangible Rewards
	Catharsis		Free Association		Milieu Therapy		Psychoeducation, Parent		Therapist Praise/Rewards
	Cognitive/Coping		Functional Analysis		Mindfulness		Relationship or Rapport Building		Thought Field Therapy
	Commands/ Limit Setting		Guided Imagery		Modeling		Relaxation		Time Out
	Communication Skills		Hypnosis		Motivational Interviewing		Response Cost		Twelve-step Programming
	Crisis Management		Ignoring or DRO		Natural and Logical Consequences		Response Prevention		Other:
	Directed Play		Insight Building		Parent Coping		Self-Monitoring		Other:
	Educational Support		Interpretation		Parent-Monitoring		Self-Reward/ Self-Praise		Other:
	Emotional Processing		Line of Sight Supervision		Parent Praise		Skill Building		
	Exposure		Maintenance or Relapse Prevention		Peer Modeling or Pairing		Social Skills Training		

Projected End Date: _____

Medication/Dosage: _____ No change _____ Change _____

Comments/Suggestions (***attach additional sheets if necessary***)**:**

Outcome Measures: Optional. If you have any of the following data, please report the most recent scores:

CAFAS (8 Scales): (1:) (2:) (3:) (4:) (5:) (6:) (7:) (8:) (Total:)			Date:
CALOCUS (Total):	CALOCUS (Level of Care):		Date:
CBCL (Total Problems T):	CBCL (Internalizing T):	CBCL (Externalizing T):	Date:
YSR (Total Problems T):	YSR (Internalizing T):	YSR (Externalizing T):	Date:
TRF (Total Problems T):	TRF (Internalizing T):	TRF (Externalizing T):	Date:
Arrested? (Y/N):	School attendance (% of days):		

Provider Agency & Island: _____ Clinician Name and ID#: _____
Provider Signature: _____ Clinician Signature: _____
Mail ☐ Fax ☐ to FGC (date): _____ Care Coordinator: _____ Date FGC Rec'd: _____